SERFF Tracking Number:	*MUTM-126591647*	*State:*	*Arkansas*
Filing Company:	*United of Omaha Life Insurance Company*	*State Tracking Number:*	*45466*
Company Tracking Number:	*PHILIP BOLL*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*Statement to Examiner - D076LNA10A*		
Project Name/Number:	*Statement to Examiner/D076LNA10A*		

Filing at a Glance

Company: United of Omaha Life Insurance Company

Product Name: Statement to Examiner - D076LNA10A	SERFF Tr Num: MUTM-126591647	State: Arkansas
TOI: L08 Life - Other	SERFF Status: Closed-Approved-Closed	State Tr Num: 45466
Sub-TOI: L08.000 Life - Other	Co Tr Num: PHILIP BOLL	State Status: Approved-Closed
Filing Type: Form		Reviewer(s): Linda Bird
	Authors: Kim Meyerring, Krysia Gannon, Ellen Cochrane, Philip Boll	Disposition Date: 04/21/2010
	Date Submitted: 04/20/2010	Disposition Status: Approved-Closed
Implementation Date Requested: On Approval		Implementation Date:

State Filing Description:

General Information

Project Name: Statement to Examiner	Status of Filing in Domicile:
Project Number: D076LNA10A	Date Approved in Domicile:
Requested Filing Mode: Review & Approval	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Individual
Submission Type: New Submission	Group Market Size:
Overall Rate Impact:	Group Market Type:
Filing Status Changed: 04/21/2010	Explanation for Other Group Market Type:
	State Status Changed: 04/21/2010
Deemer Date:	Created By: Ellen Cochrane
Submitted By: Krysia Gannon	Corresponding Filing Tracking Number:

Filing Description:

April 20, 2010

Arkansas Department of Insurance
Attn: Compliance - Life & Health
1200 West Third Street
Little Rock, AR 72201-1904

SERFF Tracking Number:	*MUTM-126591647*	*State:*	*Arkansas*
Filing Company:	*United of Omaha Life Insurance Company*	*State Tracking Number:*	*45466*
Company Tracking Number:	*PHILIP BOLL*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*Statement to Examiner - D076LNA10A*		
Project Name/Number:	*Statement to Examiner/D076LNA10A*		

RE: United of Omaha Life Insurance Company
NAIC #: 261-69868 FEIN #: 47-0322111
Individual Life Insurance
Form Number:
D076LNA10A Statements to Examiner Supplement for Life Insurance Application

On behalf of United of Omaha Life Insurance Company, I am submitting the above captioned form in final printed format for review and approval. The above captioned form is new and will replace form MLU21727, which your department approved on March 31, 2000.

We will use form D076LNA10A during the application process for fully underwritten life insurance policies. When a proposed insured applies for a fully underwritten life insurance policy, a medical professional will examine the proposed insured by completing form D076LNA10A. Form D076LNA10A will attach to and become a part of the application for a fully underwritten life insurance policy.

Form D076LNA10A will be used with application forms C977LNA09A, C978LNA09A, and C979LNA09A which your department approved on September 30, 2009. This form is being submitted for general use with all of our current and future approved fully underwritten products.

Form D076LNA10A has achieved a minimum Flesch Score of 40 when scored with the base policy and application.

The required filing materials are enclosed. Thank you for your consideration of this submission. Please feel free to contact me if you have any questions or concerns.

Sincerely,

Philip Boll
Product and Advertising Compliance Analyst
Regulatory Affairs
Phone: 402-351-2449
Fax: 402-351-5298
E-mail: Philip.Boll@mutualofomaha.com

Company and Contact

Filing Contact Information

SERFF Tracking Number:	*MUTM-126591647*	*State:*	*Arkansas*
Filing Company:	*United of Omaha Life Insurance Company*	*State Tracking Number:*	*45466*
Company Tracking Number:	*PHILIP BOLL*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*Statement to Examiner - D076LNA10A*		
Project Name/Number:	*Statement to Examiner/D076LNA10A*		

Philip Boll, Product & Advertising Compliance Analyst
philip.boll@mutualofomaha.com
Mutual of Omaha
Mutual of Omaha Plaza
Omaha, NE 68175
402-351-2449 [Phone]
402-351-5298 [FAX]

Filing Company Information

United of Omaha Life Insurance Company	CoCode: 69868	State of Domicile: Nebraska
Mutual of Omaha Plaza	Group Code: 261	Company Type: Life Insurance
Omaha, NE 68175	Group Name:	State ID Number:
(402) 351-6420 ext. [Phone]	FEIN Number: 47-0322111	

Filing Fees

Fee Required?	Yes
Fee Amount:	$50.00
Retaliatory?	No
Fee Explanation:	
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
United of Omaha Life Insurance Company	$50.00	04/20/2010	35806044

SERFF Tracking Number:	*MUTM-126591647*	*State:*	*Arkansas*
Filing Company:	*United of Omaha Life Insurance Company*	*State Tracking Number:*	*45466*
Company Tracking Number:	*PHILIP BOLL*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*Statement to Examiner - D076LNA10A*		
Project Name/Number:	*Statement to Examiner/D076LNA10A*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	04/21/2010	04/21/2010

SERFF Tracking Number:	*MUTM-126591647*	*State:*	*Arkansas*
Filing Company:	*United of Omaha Life Insurance Company*	*State Tracking Number:*	*45466*
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TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*Statement to Examiner - D076LNA10A*		
Project Name/Number:	*Statement to Examiner/D076LNA10A*		

Disposition

Disposition Date: 04/21/2010
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*MUTM-126591647*	*State:*	*Arkansas*
Filing Company:	*United of Omaha Life Insurance Company*	*State Tracking Number:*	*45466*
Company Tracking Number:	*PHILIP BOLL*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*Statement to Examiner - D076LNA10A*		
Project Name/Number:	*Statement to Examiner/D076LNA10A*		

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		No
Supporting Document	AR Fee Schedule Cert		Yes
Form	Statements to Examiner Supplement for Life Insurance Application		Yes

SERFF Tracking Number:	*MUTM-126591647*	*State:*	*Arkansas*
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Form Schedule

Lead Form Number: D076LNA10A

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	D076LNA10A	Application/ Enrollment Form	Statements to Examiner Supplement for Life Insurance Application	Initial		40.000	D076LNA10A.pdf

United of Omaha Life Insurance Company

A Mutual *of* Omaha Company
Mutual of Omaha Plaza, Omaha, NE 68175

Statements to Examiner Supplement for Life Insurance Application

Proposed Insured Legal Name _____

Date of Birth _____ Social Security No. _____

Legal Residence Address _____
Street

_____
City State ZIP Code

1. Does the Proposed Insured currently have a personal physician? ☐ **Yes** ☐ **No**
If answered "Yes," please list details below. If more space is needed use an additional sheet of paper.

Name, Address, and Telephone Number of Personal Physician	Date last seen	State Reason, Findings and treatment

2. Has the Proposed Insured ever been diagnosed by a member of the medical profession or been tested positive for Human Immunodeficiency Virus (AIDS virus) or Acquired Immune Deficiency Syndrome (AIDS)? ☐ **Yes** ☐ **No**

	Yes	No
3. Has the Proposed Insured ever (a) received treatment for, or (b) been advised by a member of the medical profession to seek treatment regarding:		
(a) any disease, or abnormal condition of the heart, circulatory system, or blood vessels, including high blood pressure, abnormal heart rhythm, valvular disease, or murmur, coronary artery blockage, chest pain, or stroke/mini-stroke?	☐	☐
(b) any disease of the lungs, or respiratory system, including tuberculosis, asthma, chronic bronchitis, emphysema, or shortness of breath?	☐	☐
(c) any digestive system disease, including ulcer, abdominal, or stomach pain, liver, or gallbladder disease, hepatitis, cirrhosis, colitis, or other colon, intestinal, or rectal disorder?	☐	☐
(d) any urinary, or reproductive system disease including protein, blood, or sugar in the urine; tumor, cysts, infection, or failure of the kidney; tumor, or disease of the prostate, testis, breasts, uterus, or ovaries?	☐	☐
(e) any brain, nerve, or mental disorder, including convulsions/epilepsy, headaches, blackouts, tremors, balance disorders, multiple sclerosis, paralysis, dementia, depression, or schizophrenia?	☐	☐
(f) any bone, or joint disorder, arthritis, or rheumatic conditions, including lupus, rheumatoid arthritis, scleroderma, fibromyalgia, or other bodily deformity, amputation, back, or spinal disorder?	☐	☐
(g) any disease, or disorder of vision, or hearing?	☐	☐
(h) cancer, tumor, blood/bleeding disorder, diabetes, thyroid, or other glandular/ metabolic disorder?.....	☐	☐

	Yes	No
4. In the past 10 years, has the Proposed Insured:		
(a) used alcohol to a degree that required treatment, or been advised to limit, or discontinue its use by a physician, or other health care provider?	☐	☐
(b) used unlawful drugs in any form (including cocaine, marijuana, methamphetamines and hallucinogens), or used prescription drugs other than as prescribed (including sedatives, tranquilizers, or narcotics) in any form?..	☐	☐
(c) been, or are currently a member of Alcoholics Anonymous, or Narcotics Anonymous?	☐	☐
5. In the past 12 months, has any person proposed for insurance:		
(a) required the assistance of another person, or a device of any kind for bathing, dressing, eating, toileting, getting in and out of a chair or bed, or the management of bowel, or bladder problems?	☐	☐
(b) received, or been advised to have, any of the following types of care: nursing home, assisted living facility, adult day care facility, home health care services, or physical, occupational, or speech therapy?	☐	☐
(c) used any of the following: walker, wheelchair, electric scooter, oxygen, or catheter?	☐	☐
(d) applied for, received, or are you currently receiving disability, hospital, or medical benefits from any insurance company, government, employer, or other source other than for maternity?..	☐	☐

6. In the past two years, has the Proposed Insured (a) been prescribed medication, or (b) taken any medication prescribed by a physician, or (c) regularly used over-the-counter medication? ☐ **Yes** ☐ **No**

If answered "Yes", please list details below. If more space is needed, provide answers in number 9 of this application.

Medication Name (Copy from Pharmacy Label)	Date Last Taken	Prescribing Physician (if any)	Reason	Dosage Frequency

7. In the past five years, has the Proposed Insured consulted with a doctor or been hospitalized or treated by a health care provider for any other health condition? ☐ **Yes** ☐ **No**

If answered "Yes", please list details below. If more space is needed, provide answers in number 9 of this application.

Medical Impairment, Injury, Illness or Results of Testing or Examinations (If operation was performed, state type)	Month and Year	Duration	Degree of Recovery	Name, Address, ZIP and Telephone Number of Hospital, and/or Attending Physician

8. Family History

Please list details below for the Proposed Insured (If applicable).

	Age at Death	If Living Present Health - If Deceased, Cause of Death
Father		
Mother		
Sibling 1		
Sibling 2		
Sibling 3		

9. List details of "Yes" answers. Identify question number and provide any additional information necessary. If more space is needed, use additional sheet of paper.

_____

_____

_____

_____

_____

_____

All answers in this application are true and complete, to the best of my knowledge and belief, and will be relied on by United of Omaha Life Insurance Company to determine insurability. The statements and answers in the application are the basis for any policy issued by United of Omaha Life Insurance, and no information about them will be considered to have been given to United of Omaha Life Insurance Company unless it is stated in the application. Any incorrect or misleading answers may void this application and any issued policy effective the issue date. This application is to be attached to and made a part of the policy.

Fraud Warning: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

Signed at: _____ _____ Date _____

City State Mo Day Yr

Witness _____ _____

Signature of Examiner Signature of Proposed Insured

SERFF Tracking Number:	*MUTM-126591647*	*State:*	*Arkansas*
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Supporting Document Schedules

Item Status: **Status Date:**

Satisfied - Item: Flesch Certification
Comments:
Attachment:
AR Read Cert.pdf

Item Status: **Status Date:**

Bypassed - Item: Application
Bypass Reason: Please see the application attached under the Form Schedule tab.
Comments:

Item Status: **Status Date:**

Satisfied - Item: AR Fee Schedule Cert
Comments:
Attachment:
AR Fee Schedule Cert .pdf

ARKANSAS

CERTIFICATION

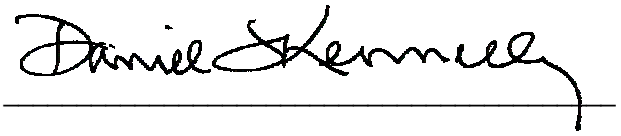
This is to certify that the attached form(s) has/have achieved the following Flesch Reading Ease Score(s) and complies/comply with the requirements of Ark. Stat. §§66-3251 through 66-3258, cited as the Life and Disability Insurance Policy Language Simplification Act.

Form	Description	Score
D076LNA10A	Statements to Examiner Supplement	40*

*Meets or exceeds your Flesch score requirement of 40 when scored with the base application and policy.

United of Omaha Life Insurance Company

Date: April 20, 2010



Daniel J. Kennelly
Vice President & Chief Compliance Officer

ARKANSAS
INSURANCE
DEPARTMENT

400 University Tower Building
1123 South University Ave.
Little Rock, Arkansas 72204

Lee Douglass
Insurance Commissioner

ATTN: LIFE & HEALTH DIVISION, ARKANSAS INSURANCE DEPARTMENT

Company Name: United of Omaha Life Insurance Company

Company NAIC Code: 261-69868
Company Contact Person & Phone: Philip Boll 402-351-2449

INSURANCE DEPARTMENT USE ONLY:

ANALYST: _____ AMOUNT: _____ ROUTE SLIP: _____

ALL FEES ARE PER EACH INSURER, PER ANNUAL STATEMENT LIFE OF BUSINESS, UNLESS OTHERWISE INDICATED.

FEE SCHEDULE FOR ADMITTED INSURERS

RATE/FORM FILINGS

Life and/or Disability policy form filing and review, per each policy, contract, annuity form, per each insurer, per each filing.	* 1 X $50 = $ 50.00 **Retaliatory $ _____
Life and/or Disability - Filing and review of each rate filing or loss ratio guarantee filing, per each insurer.	* _____ X $50 = _____ **Retaliatory $ _____
Life and/or Disability Policy, Contract or Annuity Forms : Filing and review of each certificate, rider, endorsement or application if each is filed separately from the basic form.	* _____ X $20 = _____ **Retaliatory $ _____
Life and/or Disability: Filing and review of Insurer's advertisements, per advertisement, per each insurer.	* _____ X $25 = $ _____ **Retaliatory $ _____

AMEND CERTIFICATE OF AUTHORITY

Review and processing of information to amend an Insurer's Certificate of Authority	* _____ X $400 = _____
Filing to amend Certificate of Authority.	*** ____ X $100 = _____

***THESE FEES ARE PAYABLE UNDER THE NEW FEE SCHEDULE AS OUTLINED UNDER RULE AND REGULATION 57.**

****THESE FEES ARE PAYABLE UNDER THE OLD FEE SCHEDULE AS OUTLINED UNDER ARK. CODE ANN. 23-63-102, RETALIATORY TAX.**

*****THESE FEES ARE PAYABLE AS REQUIRED IN ARK. ANN. SEC. 23-61-401.**